benefit strategies LLC

Welcome to your new Flex Spending Account Plan Year!

The e-mail letter this document was attached to shows your reimbursement account annual election for the upcoming plan year. Please review the election and your address to ensure accuracy, and notify Benefit Strategies or your employer of any necessary corrections.

We are pleased to announce our enhanced website which enables you to monitor your reimbursement account activity and fund balance, file claims on line, access forms and other information. To log into your account, please follow the instructions found on the next page of this document.

HOW TO ACCESS YOUR FLEX SPENDING ACCOUNT FUNDS:

1. **Submit a Flex Claim Form via Fax or Mail** – A copy of a Flex Claim Form and directions is attached with this notice. Additional forms may be obtained from your employer or from Benefit Strategies' website: www.benstrat.com under "Available Forms." Fax or mail the completed form along with documentation of your eligible expenses to Benefit Strategies. Properly completed claims are usually processed within 1 week. You may submit claims as often as you like. Do make sure, however, that the expense you are requesting reimbursement for is eligible according to IRS guidelines and that it will not be reimbursed by your insurance or any other source.

2. **NEW! - Enter Your Reimbursement Request On Line** – Log in to your account (Instructions follow), click **File Claims** and follow the instructions. Print the Confirmation page and mail it in with your receipts. Try it – it's easy!

3. ***FlexExpress*© Card Users** – If you requested a new *FlexExpress* card you will be receiving it at your home address in a plain white envelope. If you re-activated your current *FlexExpress* card(s), it has been updated with your new election.

   Remember, you may only use the card at qualified providers of health care services or products. Also, IRS regulations state you **must** retain documentation for every transaction. Benefit Strategies reserves the right to ask for documentation to verify any expenses paid with your *FlexExpress* Card. If your *FlexExpress* Card is lost or stolen, please notify us immediately.

Do you have questions? Contact Benefit Strategies!

Mailing Address:	**Telephone:**	(888) 401-FLEX (3539)
PO Box 1300	**FAX:**	(603) 647-4668
Manchester, NH 03105-1300	**e-mail:**	claimsupport@benstrat.com

WEB-SITE LOG IN INSTRUCTIONS:

1. Open your browser (e.g. Internet Explorer) and log into our website: **www.benstrat.com** .
2. Click on **FLEX: Participant Login** in the middle light blue box on the left of the homepage
3. **Log in using the following:**

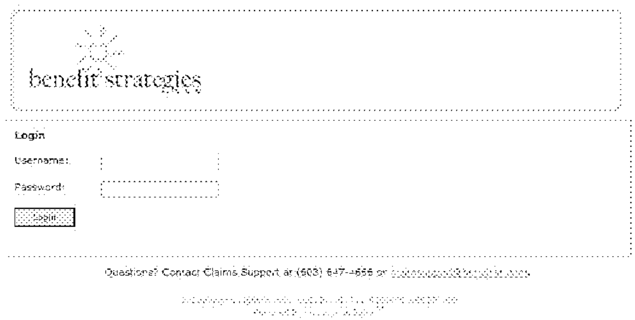
USERNAME: Your username will be your ***first name initial*** followed by your ***entire last name*** and the ***last four digits of your social security number***

Example: **Jason Smith, SSN: 121-22-3456.**
Username: *jsmith3456*

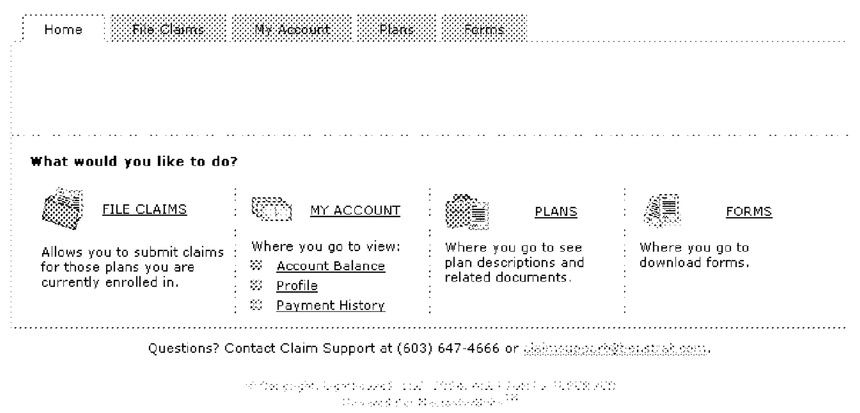
PASSWORD: ***changeme***

If this is your first time logging in to our enhanced web-site, use ***changeme*** as your password. You will then be instructed to create a new and unique password. *The password must:*

• Have a minimum of 6 characters • Not be one of your last 3 passwords
• Contain upper and lower case letters • Contain at least one number .

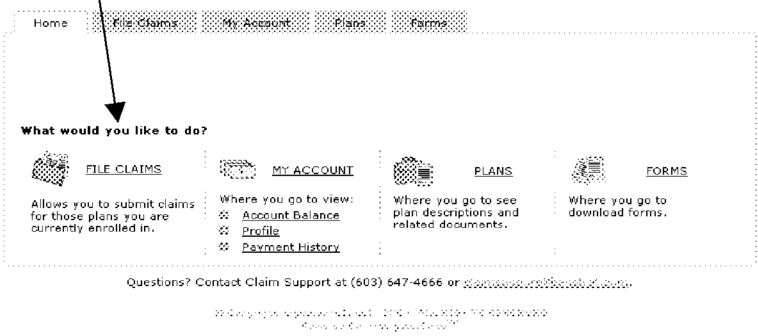


Once you have successfully logged in, you will see a screen that looks like this. From here, you may click on items to file a claim, check your real-time account balance and payment history, or get plan information or forms.

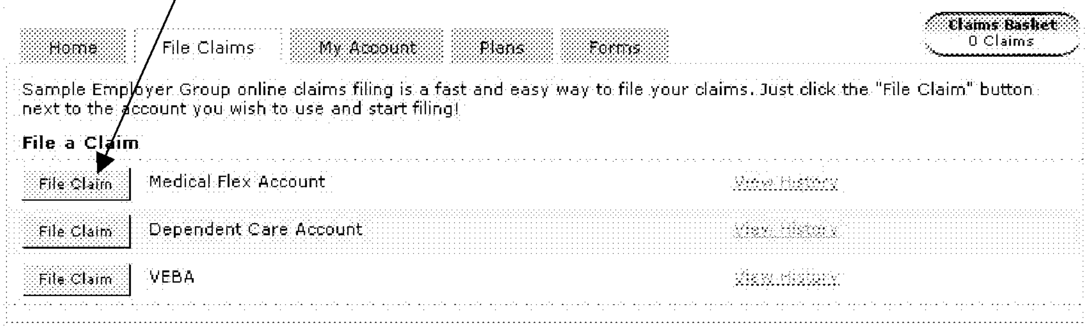


HOW TO FILE YOUR CLAIMS ONLINE

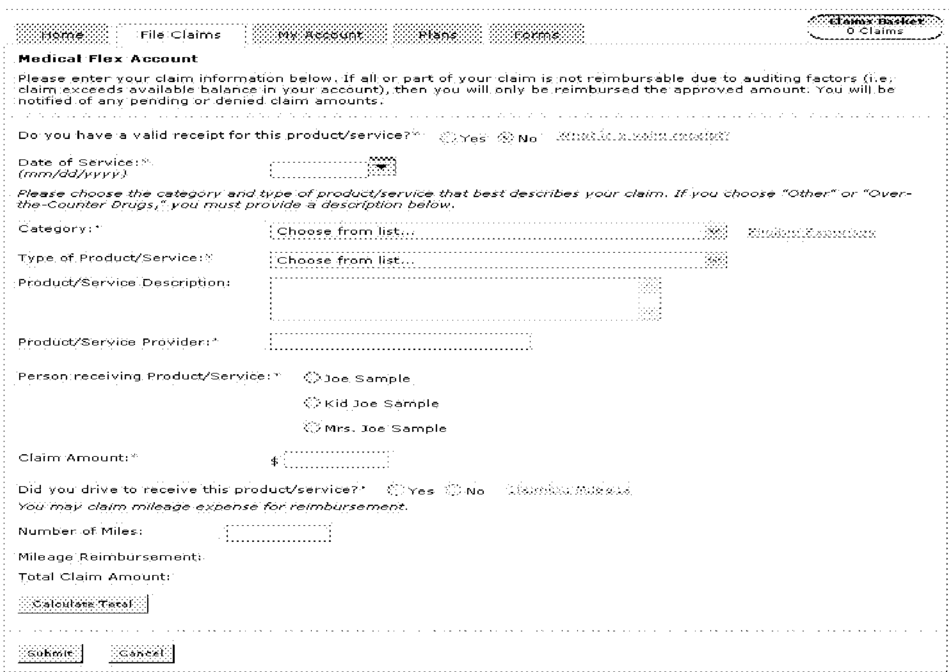
1. Click the **File Claims** tab or menu item.



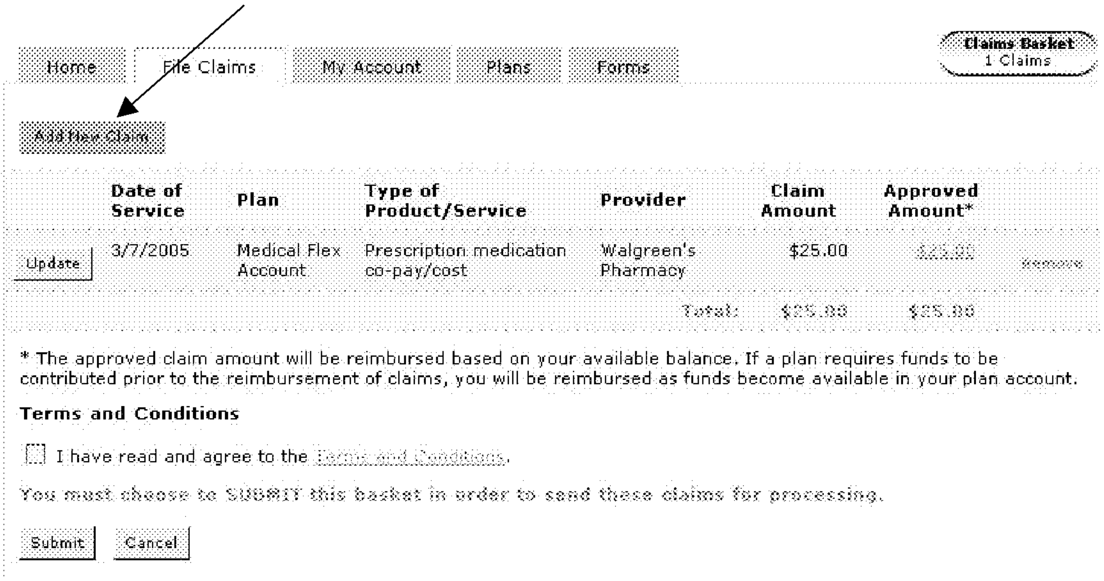
2. Click the **File Claim** button next to the plan for which you wish to file a claim.



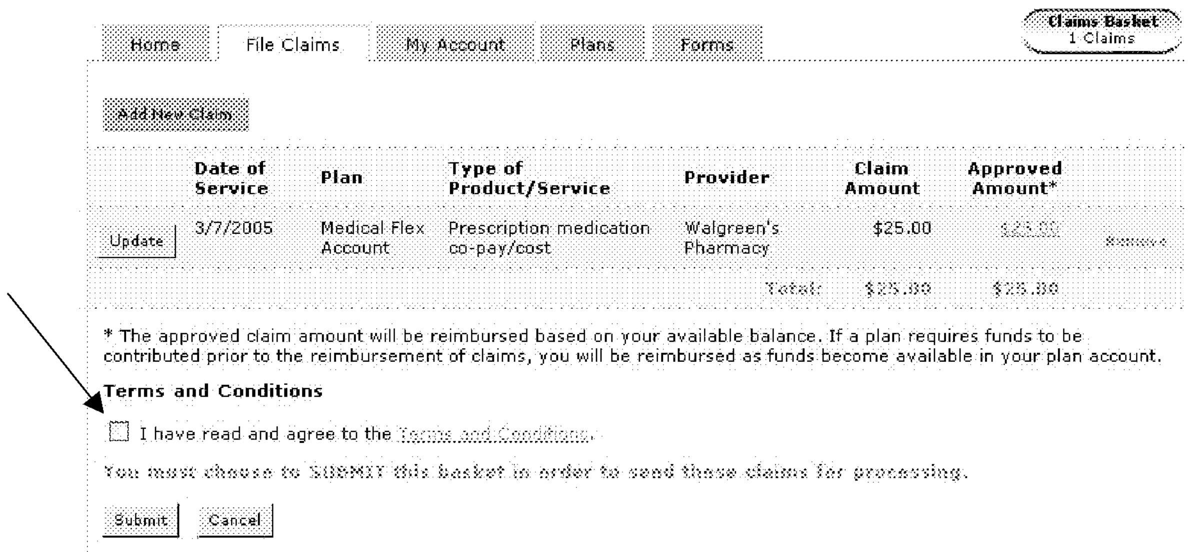
3. **Enter the information for each expense, clicking submit between each one.** Make sure you have valid receipt(s) for your expenses, as you will need to fax or mail them to Benefit Strategies.



4. If you have more than one expense to request reimbursement for, click on **Add a New Claim.** Enter information and click **Submit.**



5. Once all claims are entered, you must:
   1) Agree to the **Terms & Conditions** (click on appropriate box) and
   2) Commit the claim(s) by clicking **Submit**.



6. **PRINT AND SEND CONFIRMATION WITH RECEIPTS!**

A Confirmation Page that looks like this will come up. The confirmation page verifies that all claims have been successfully submitted! You must print this page by clicking **Print Confirmation** and mail it along with your receipts to:

Benefit Strategies
PO Box 1300
Manchester, NH 03105-1300

Or FAX to: (603) 647-4668

Home | File Claims | My Account | Plans | Forms

Joe Sample
Sample Employer Group
Order Number: SAM050307100011000

You have successfully filed the claim(s) listed below.

Custom claim submission text goes here.

Receipt(s) Required - Print this Page:

Print this confirmation, attach the required receipts and **fax or mail to Sample Administrator** at one of the contacts listed below.

Fax:
Mail:

Email:

If you are unable to print this confirmation:
Send your receipts with a note that includes (a) the name of the company you work for, (b) your name, and (c) the claim number(s) listed below.

Claim Number	Plan	Date of Service	Provider	Receipt Amount	Mileage Amount	Approved Amount*	Receipt Required
SAM05030710001100010	Medical Flex Account	3/7/2005	Walgreen's Pharmacy	$25.00	$0.00	$25.00	Yes
SAM05030710001100011	Dependent Care Account	3/1/2005 - 3/4/2005	Kinder Care	$200.00	$0.00	$200.00	Yes
			Totals:	$225.00	$0.00	$225.00	

* The approved claim amount will be reimbursed based on your available balance. If a plan requires funds to be contributed prior to the reimbursement of claims, you will be reimbursed as funds become available in your plan account.

Please send in the Required Receipt(s) listed above within 60 days. If we do not receive the receipt/s by this date, your reimbursement will be denied.

Remember, regardless of which (if any) receipts you are required to submit, you are responsible for retaining a copy of all receipts for three years in the event you or your Pre-tax Account plan are audited by the IRS.

Print Confirmation | Home | Logout

IMPORTANT NOTES ON FILING CLAIMS

1) Paper Request For Reimbursement Forms must be filled out COMPLETELY and signed. Medical expenses must FIRST be submitted to your insurance provider. Only out-of-pocket expenses incurred during your active participation in the plan year are reimbursable. (Incomplete forms **will be** returned.)

2) Mail or FAX form and copies of receipts, (***5 Page Limit for FAXES***), to Benefit Strategies at the following address:

Benefit Strategies,LLC
PO Box 1300
Manchester, NH 03105-1300
Fax: (603) 647-4668

3) Complete claims received by NOON on Thursday will usually be processed for reimbursement on Friday. **Does not apply to all clients.*

4) Copies of all third party documentation for expenses you are claiming should be submitted on 8 1/2 by 11 paper *along with* your COMPLETED Reimbursement Request. ***Please keep original receipts for your tax records.***

5) Documentation must clearly show the following:.

   a. the **date** the expense was **incurred** (NOT the date paid)
   b. the **provider** of services,
   c. a **description of the service** and/or expense, and
   d. the **charge** for each service and amount paid or denied by insurance.

   Health Care Reimbursement Account documentation can include statements, itemized bills, and/or insurance "Explanation of Benefits" forms. ***Note: Canceled checks, credit card receipts, and balance forward statements are NOT acceptable documentation.***

   Dependent Care Reimbursement Account documentation must show the dates of service, provider's name, and dependent's name. Section 4 of the Request For Reimbursement form may be used as eligible documentation. You must have on file the Taxpayer ID Number or Social Security Number of your Dependent Care providers. You will need to provide these numbers to the IRS when filing your taxes.

We hope you will find this overview helpful in getting starting with the new plan year. If you have any questions, please contact our office at (603) 647-4666. One of our operators will direct you to someone who can help you.

Thank you!

benefit strategies LLC

www.benstrat.com

FOR PARTICIPANTS

FAX CLAIMS TO:……………………………………………(603)-647-4668
CLAIM SUPPORT………………………………………….(603) 647-4666
MAIL TO: ………………..PO Box 1300, Manchester, NH 03105-1300
ONLINE ACCOUNT………https://benstrat.navigatorsuite.com/Login.aspx

CLAIM FORM : Health Care and Dependent Care Spending Accounts

Name: ______________________ Company: ______________________

Home Mailing Address: Check if NEW ☐ SSN: ______________________

Address: ______________________ Plan Year: __________ -to- __________

City: __________ State: ______ Zip: ______ Telephone: *Home:* ( ) -

Email: ______________________ *Daytime Phone:* ( ) -

List …..EXPENSES REQUESTING REIMBURSEMENT….. Use second sheet if needed.

***Note*: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable documentation.**

Amount to be Reimbursed:	Service Date(s)	DESCRIPTION	Person receiving product or service:
1.		☐ MEDICAL ☐ Dental/Ortho ☐ OTC ☐ Vision ☐ Rx ☐ ________	
2.		☐ Medical ☐ Dental/Ortho ☐ OTC ☐ Vision ☐ Rx ☐ ________	
3.		☐ Medical ☐ Dental/Ortho ☐ OTC ☐ Vision ☐ Rx ☐ ________	
4.		☐ Medical ☐ Dental/Ortho ☐ OTC ☐ Vision ☐ Rx ☐ ________	
$	**REQUIRED …** Date(s) of Service *Start:*__________ *End:* __________	CHILD CARE	

$ ______________ **TOTAL Reimbursement Requested** (Payments are made directly to the employee.)

CHILD / DEPENDENT CARE PROVIDER RECEIPT (May be used in lieu of other child care documentation)

Dependent(s) Receiving Care: ______________________

I certify that I have provided the services as listed above, and that I have been paid for these services.

Service Date Span: *From* __________ *To* __________

Provider's Name: ______________________

Provider's Signature: ______________________

INSTRUCTIONS / REMINDERS

1. Be sure to attach a **COPY** of the itemized receipt(s), or if you have insurance, please send the Explanation of Benefits Statement. **KEEP** original receipts for your tax records.
2. **Complete** claims received by NOON on Thursday will be processed on Friday.
3. The **participant** must **sign** claim form.
4. Incomplete forms **will NOT be** processed.

Health Care Reimbursement Account documentation may include statements, itemized bills, and/or insurance "Explanation of Benefits" forms.

All documentation **must show**:

A. the date the expense was **incurred** (not the date paid),
B. the provider of services.
C. a description of the service and/or expense.
D. the amount of the expense for which you are responsible.

***Note*: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable documentation.**

To the best of my knowledge and belief, my statements in this Request for Reimbursement are complete and true. I am claiming reimbursement only for eligible expenses incurred by my legal dependents or myself. I certify that these expenses have not been and will not be reimbursed from any other source and will not be claimed as an income tax deduction.

EMPLOYEE SIGNATURE: ______________________ **Date:** __________
(Required)

2/15/2006

List .....EXPENSES REQUESTING REIMBURSEMENT			
***Note*: Cancelled checks, credit card receipts, and balance forward statements are NOT acceptable documentation.**			
Amount to be Reimbursed:	Service Date(s)	DESCRIPTION	Person receiving product or service:
		☐ Medical ☐ Dental/Ortho ☐ OTC ☐ Vision ☐ Rx ☐ ____________	
		☐ Medical ☐ Dental/Ortho ☐ OTC ☐ Vision ☐ Rx ☐ ____________	
		☐ Medical ☐ Dental/Ortho ☐ OTC ☐ Vision ☐ Rx ☐ ____________	
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		☐ Medical ☐ Dental/Ortho ☐ OTC ☐ Vision ☐ Rx ☐ ____________	
$ ______________________ **TOTAL Reimbursement Requested** (Payments are made directly to the employee.)			

Rev: 1/24/06